children are boys, and 50% to 75% are under 2 years of age.[2-4]

Infants tend to have an acute illness lasting only 1 or 2 days, most often in the spring or summer; 85% to 90% have pain, 80% to 90% vomiting, 50% to 65% a palpable mass and 45% to 65% blood per rectum.[2-4] In adults the diagnosis is seldom made preoperatively; the signs and symptoms are more variable and tend to be less impressive and chronic, persisting often many months when due to benign disease, many weeks when due to primary malignant disease and perhaps several weeks when due to metastases in the bowel.[5-11] Children older than 2 years may experience a clinical course intermediate between those of infants and adults.[12]

Whereas most intussusceptions in children (48% to 85%) are ileocolic,[2-4] most of those in adults involve the small bowel, with 17% to 52% (average 30%) being colonic.[6-10]

The frequency with which organic disease can be identified as the precipitant of intussusception and the leadpoint of the intussusceptum differs substantially between adults and infants, and is intermediate for children over 2 years of age.[12] In infants an organic cause is found in only 8% to 26% (average about 10%), and Meckel's diverticulum is the most frequent.[2-4] In adults an organic cause is found in 66% to 90% (average about 80%),[5,6,8-10] though there have been small series reported in which idiopathic intussusception constituted 33% to 50% of cases in adults.[7,10] Neoplasms, benign or malignant, cause an average of 60% of cases in adults; another 20% are due to inflammatory lesions, Meckel's diverticulum and more exotic precipitants, such as blunt and penetrating trauma, foreign bodies, appendiceal mucocele, appendiceal invagination and heterotopic pancreatic tissue.[5,6,8]

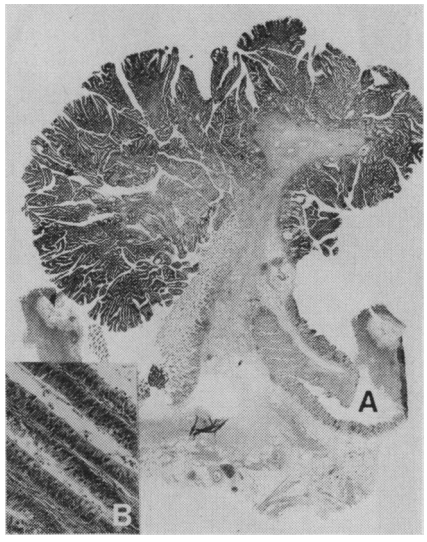

FIG. 4—A: whole-mount cross-section of villous adenoma, with normal ileal mucosa to the left and colonic mucosa to the right (hematoxylin–eosin [H–E]; original magnification ×5). B: slightly dysplastic glandular epithelium forms delicate papillary fronds of adenoma (H–E; original magnification ×60).

Among the intussusceptions secondary to neoplasm in adults there are important differences between those in the small and large bowel. Of the cases involving the small bowel, benign neoplasms are found in about 30% and malignant neoplasms in 10% to 25%;[6,8] thus, 55% to 75% of all enteric neoplasms associated with intussusception are benign and 25% to 45% are malignant.[5,6,8] Adenomas, lipomas and fibromas predominate among the benign neoplasms, and adenocarcinomas and soft tissue sarcomas predominate among the malignant neoplasms.[5,6] Melanoma is probably the most common meastastasis.[11] Of the cases involving the large bowel, which are less frequent, more are caused by neoplasms: benign neoplasms account for 21% to 38% and malignant neoplasms for 48% to 68%; thus, 27% to 40% of all colonic neoplasms causing intussusception are benign and 60% to 73% are malignant.[5,6,8] Lipomas and adenomas are the most common of the benign neoplasms, and adenocarcinomas are the most common of the malignant.[5,6]

It is because of the frequency of neoplasia that the preferred treatment of intussusception in adults is surgical, usually segmental resection with end-to-end anastomosis, rather than barium enema reduction, as attempted in children.[2,3,8-10]

The case we have reported illustrates the rather nonspecific signs and symptoms of intermittent bowel obstruction seen in adults with intussusception; a barium enema fortuitously demonstrated the nature of the obstruction. Ileocecocolic (as in this case) and cecocolic intussusceptions account for about 15% to 25% of intussusceptions in adults, but an abnormal ileocecal valve as a leadpoint is extremely rare.[5,6,8] The only such case previously reported was one of "hypertrophy" of the valve.[5] Our case is more remarkable in view of the relative scarcity of villous adenomas in the right colon; they have been reported as accounting for 0 to 17% of various series of neoplasms in this area, though this figure may be altered as colonoscopic visualization and biopsy of the right colon becomes more frequent.[13] The circumferential growth of the ileocecal adenoma in our patient is a further unusual aspect of the case.

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BOOKS

This list is an acknowledgement of books received. It does not preclude review at a later date.

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CLINICAL RHEUMATOLOGY. Second Edition. A Problem-Oriented Approach to Diagnosis and Management. Roland W. Moskowitz. 421 pp. Illust. Lea & Febiger, Philadelphia, 1982. $30. ISBN 0-8121-0847-7

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THE EASTER SEAL GUIDE TO CHILDREN'S ORTHOPAEDICS. Prevention, Screening and Problem Solving. Mercer Rang. 97 pp. Illust. The Easter Seal Society, Toronto, 1982. $5, paperbound

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ESTABLISHING A GERIATRIC SERVICE. Edited by Davis Coakley. 235 pp. Illust. Croom Helm Ltd., London, 1982. £14.95. ISBN 0-7099-0700-1

THE FERTILITY QUESTION. Margaret Nofziger. 104 pp. Illust. The Book Publishing Company, Summertown, Tennessee, 1982. $6.25, paperbound. ISBN 0-913990-43-4

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GENITOURINARY CANCER SURGERY. Edited by E. David Crawford and Thomas A. Borden. 575 pp. Illust. Lea & Febiger, Philadelphia, 1982. $118.25. ISBN 0-8121-0812-4

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INTERPRETING THE MEDICAL LITERATURE. A Clinician's Guide. Stephen H. Gehlbach. 234 pp. Illust. D.C. Heath Canada Ltd., Toronto, 1982. $16.25, paperbound. ISBN 0-669-04506-3

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